health information designs

Eucrisa
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Eucrisa must meet the following criteria:

Initial Requests:

- Patient must be 2 years of age or older
- Patient must have an FDA-approved diagnosis for use
- Patient must have had a 30 day trial within the past 180 days of one of the following:
  - A topical calcineurin inhibitor (tacrolimus or pimecrolimus)
  - A topical corticosteroid.

Renewal Requests:

- Documentation from the prescriber must be provided showing that the patient has achieved a significant reduction in severity of atopic dermatitis (please attach documentation to this request)

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code

Requested Drug: □ EUCRISA	**Diagnosis for this request:**	**Is the affected area is on the face, groin, axilla, or under occlusion?** □ YES □ NO

List all failed medications:	**Start Date:**	**End Date:**

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #